

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**Medicare Losses Resulting from Early
Payments for Durable Medical Equipment,
Prosthetics, Orthotics, and Supplies**



**JUNE GIBBS BROWN
Inspector General**

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OEI-03-99-00620**

OFFICE OF INSPECTOR GENERAL

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June Gibbs Brown
Inspector General

OIG Final Report: “Medicare Losses Resulting from Early Payments for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies,” OEI-03-99-00620

Nancy-Ann Min DeParle
Administrator
Health Care Financing Administration

Summary

The purpose of this report is to inform the Health Care Financing Administration (HCFA) of an improvement that can be made to provider billing requirements for durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS). We found that the Medicare trust fund would have earned significant interest if HCFA had required providers to wait until the end of the service period to submit DMEPOS claims. We estimate this unearned interest to be \$7.2 million in 1998.

Background

Title XVIII of the Social Security Act authorizes coverage of durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) under Medicare Part B. Medicare allowed approximately \$6.1 billion for DMEPOS claims in 1998. Durable medical equipment includes items such as hospital beds, wheelchairs, and oxygen equipment. Prosthetics, orthotics, and supplies include such items as artificial arms and legs, neck braces, enteral nutrients, and wound dressings. Depending on the type of DMEPOS, these services can be rented on a monthly basis, purchased, or billed over a number of days corresponding to the amount of the supply provided.

According to the Medicare Carriers Manual, Part B expenses for items and services are incurred on the date the beneficiary receives the item or service. For DMEPOS claims, expenses are incurred on the date the item is delivered to the beneficiary’s home. This date is also known as the “date of service” and is the earliest date that a provider can submit a claim. For rental items, the day of delivery is the initial date of service for the monthly rental period, and subsequent rental periods start on that same day of the month.

The Supplementary Medical Insurance (SMI) trust fund pays for physician and outpatient services under Part B of the Medicare Program. The SMI is financed by monthly premiums charged to Medicare beneficiaries and by payments from Federal general revenues. The money in the trust fund is invested in special Treasury securities that are guaranteed by the U.S. Government. Those securities that are available only to the trust fund are called special issues. The rate of interest on special issues is determined by a formula and is established at

the end of each month. This rate of interest applies to new investments in the following month. The average interest rate for 1998 was 5.625 percent.

Methodology

Claims Data. We gathered all 1998 DMEPOS claims for a 1 percent sample of Medicare beneficiaries using HCFA's National Claims History file. From this file, we used variables associated with the service start date, service end date, carrier receipt date (i.e., date carrier receives claim from provider), type of service code (e.g., rental or purchased item), and allowed amount.

To determine if a provider billed Medicare for a service before it was completed, we compared the carrier receipt date to the service end date. Almost all (99.9 percent) of the rental claims that we reviewed had the same start and end dates of service. For these claims, we created a new end date by adding 30 days to the date of service provided on the claim. We did this since rental services span a monthly period and these dates of service did not accurately reflect the service period. For all the remaining services, we used the actual end date of service. We then identified those services where the carrier receipt date preceded the service end date. For these services, we subtracted the carrier receipt date from the end date of service to calculate the number of days in interest that Medicare lost. Using the average 1998 interest rate on special-issue investments issued to the SMI trust fund, we calculated a daily interest rate by dividing the 1998 interest rate by 365 days. To calculate the total interest lost for each service, we first multiplied the number of days lost in interest by the daily interest rate then multiplied that amount by the service's allowed amount. We then aggregated the results for all identified services.

We also analyzed when, during the service period, providers submitted these claims. To determine this, we found the mid-point of each service period by dividing the number of days in the service period by two. We then subtracted the carrier receipt date from the end date of service and compared this number to the mid-point of the service period. If the number was greater than or equal to the mid-point, we determined that the service was billed in the first half of the service period. If the number was less than the mid-point, we determined that the service was billed in the second half of the service period. Additionally, if the carrier receipt date was before the start date of service, we determined that the service was billed before the start of the service period.

Survey Data. To determine what other payers' billing and payment policies for rental services were, we conducted phone surveys with representatives of seven fee-for-service health benefit plans offered under the Federal Employees Health Benefits Program.

Findings

Medicare could have earned an additional \$7.2 million in interest on 1998 payments for claims that were billed before the end of the service period

Medicare could have earned an additional \$7.2 million (\pm \$40,348) in interest on 1998 payments for DMEPOS services. This is due to the current Medicare policy that allows providers of DMEPOS to bill for a service before the service period is completed. Rental claims accounted for almost all (98 percent) of the identified claims. For the majority of services, claims were submitted by providers during the first half of the service period. Additionally, a small number of services were billed even before the start date of service. The table below shows the percentage of services billed in each segment of the service period along with the estimated interest Medicare could have earned.

Percentage of 1998 Services Billed and Estimated Unearned Interest by the Segment of the Service Period		
Segment of Service Period Billed	Percentage of Total Services Billed	Estimated Unearned Interest
Before Start Date of Service	0.2%	\$21,855
First Half of Service Period	83.6%	\$6,703,059
Second Half of Service Period	16.2%	\$434,992
Total	100.0%	\$7,159,906

Four of seven insurers surveyed do not pay for services before the service period is completed

We asked seven insurers if we were to rent a wheelchair to a member for the month of January, (1) when would we be allowed to submit the claim and (2) when would we be paid. Two insurers said that their systems would reject the claim if it was submitted before the end of the service period. Another two insurers said that if the claim for the wheelchair was submitted early they would hold payment of the claim until the end of the service period. The other three insurers surveyed said the claim can be submitted at the beginning of the service period and that payment would not be delayed until the end of the service period.

Recommendation

We believe that HCFA is allowing unnecessary losses to the Medicare trust fund, in the form of unearned interest, by paying for DMEPOS claims prior to the end of the service period.

Therefore, we recommend that HCFA not pay for DMEPOS claims before the service period has been completed. To accomplish this, HCFA should:

- ▶ ***require providers to submit claims at the end of the service period;***
- ▶ ***require providers to submit claims with accurate start and end dates of service;***
- ▶ ***require a Common Working File and/or contractor system edit to reject claims submitted prior to the end of the service period.***

Agency Comments

The HCFA did not concur with our recommendation and stated that delaying payment of DMEPOS claims until the end of the service period would not be a desirable practice. In addition, HCFA questioned our use of the carrier receipt date in our interest calculation and stated that our estimate of \$7.2 million would likely be reduced if we had factored the 14-day payment floor into our calculation. The 14-day payment floor requires contractors to hold claims for 14 days before being paid. The full text of HCFA's comments is attached.

OIG Response

We recognize that HCFA needs to prioritize the issues it addresses based on impact to the program, and we realize that the \$7.2 million financial impact of our recommendation may need to be balanced against other agency goals. We suggest that, if it is not practical to take action now, HCFA reconsider our recommendation at a later time when making additional or broader refinements to Medicare's claims processing system.

We do believe there is evidence that paying for DMEPOS claims at the end of the service period is a viable option. While HCFA believes that such a practice would be inconsistent with customary business practices, we found that four of seven insurers contacted paid for these types of services at the end of the service period.

We would also like to clarify a technical issue raised by HCFA with respect to our interest lost estimate. The HCFA questioned our use of carrier receipt date to determine the interest lost by early payment of DMEPOS claims, and stated that we did not take into account the 14-day payment floor. Using the premise that DMEPOS claims should not be billed until the end of the service period, our methodology determined that a claim covering the month of January and received on January 5 would have lost 26 days of interest. The HCFA states that we

should have added 14 days to the January 5 receipt date to determine an estimated payment date of January 19. If we had used this payment date in our calculation, HCFA believes that the interest lost would be reduced to only 12 days in this example. However, if we had used the estimated payment date to calculate interest lost, the program still would have lost 26 days of interest. If we replaced receipt date with payment date in the calculation, we would have subtracted the estimated payment date of January 19 from the proposed payment date of February 14 (proposed receipt date plus 14 days), not from the proposed receipt date of January 31. When payment date is applied uniformly in the calculation, the number of days of interest lost to the Medicare program is 26 days. Whether receipt date or payment date is used to calculate interest lost, the result is the same. Therefore, we believe our \$7.2 million estimate is an accurate reflection of the interest lost to the program in 1998.

Attachment



DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration

DATE: MAY 26 2000**TO:** June Gibbs Brown
Inspector General**FROM:** Nancy-Ann Min DeParle
Administrator

A handwritten signature in black ink, reading "Nancy-Ann Min DeParle", is written over the printed name of the Administrator.

SUBJECT: Office of the Inspector General (OIG) Draft Report: "Medicare Losses Resulting from Early Payment for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies" (OEI-03-99-00620)

We appreciate the opportunity to comment on this draft report on durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS). HCFA is legally bound to pay provider claims once a service is rendered. However, by the time the payment floor is considered, HCFA is already paying 14 days into the billing cycle -- if the final OIG report were to reflect this payment lag, we believe the \$7.2 million estimate would likely be reduced. Even an estimate of \$7.2 million in potential savings represents only .1 percent of DME annual expenditures of \$6.1 billion.

We appreciate the OIG's recognition of our significant work to pay claims promptly. HCFA does agree that paying later in the service period may allow the trust fund to accrue additional interest. However, in order to accomplish this billing practice we would have to pay for DME services differently than other Medicare covered services. In addition, the OIG's analysis presumes that all HCFA payments occur on the date of the claim. The OIG has assumed that HCFA pays claims almost immediately upon receipt, and that since most of the claims were submitted in the first half of the service period, they were also paid during the first half of the service period. A more appropriate measurement should be the average interval between Medicare's receipt and payment of DME claims -- and the 14 day payment floor should be reflected in the calculation of interest, rather than the date of receipt of the claim.

The OIG also suggests that payment be made at the end of a rental period, rather than when a service is rendered. Delay of payment until after a rental period has closed would not be a desirable practice. Such a practice would also be inconsistent with customary business practices, wherein payment for a rented item is due at or before the beginning of the rental period. In addition, since there are other areas where HCFA makes payments at the beginning of a service period, such as managed care payments, any change in DMEPOS payments to the end of the service period should be considered in the broader context of payments to other providers.

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HCFA and the private companies that process Medicare claims have taken steps to ensure that Medicare pays reasonable prices for needed medical equipment. In 1999, Medicare conducted more than 22,000 site visits of suppliers, denying more than 200 applicants and revoking more than 2,800 existing Medicare supplier numbers. We will soon publish proposed new standards for all suppliers to better protect beneficiaries and taxpayers from unscrupulous practices. Using the inherent reasonableness authority obtained in the Balanced Budget Act of 1997, we have put forward proposals to reduce excessive charges on certain items to save millions of dollars for beneficiaries and the Medicare program. However, last year, Congress prohibited us from proceeding with these efforts until after the General Accounting Office releases a report on the issue. GAO has presented us with a draft copy of this report for comment and we look forward to moving ahead on these important efforts.

In addition, we are using private-sector competition to save an average of 17 percent for beneficiaries and the Medicare program on certain durable medical equipment (DME) as part of a competitive-bidding demonstration in Polk County, Florida. We plan to include off-the-shelf orthotic devices, such as braces and splints, in a second demonstration planned for San Antonio.

These efforts are just part of our broader strategy for protecting Medicare today and into the future. Since 1993, the Clinton Administration has done more than any previous administration to fight waste, fraud and abuse of the Medicare program, which pays more than \$200 billion each year for health care for nearly 40 million beneficiaries. The result is a record series of investigations, indictments and convictions, as well as new management tools to identify improper payments to health care providers. Last year, the Federal government recovered nearly \$500 million as a result of health-care prosecutions. Medicare has also reduced its improper payment rate sharply from 14 percent 4 years ago to less than 8 percent last year, and HCFA is committed to achieving further reductions in the future.

Technical Comment

Under the Methodology section, the OIG used the carrier receipt date as the date to begin calculating "the number of days in interest that Medicare lost". We disagree with the selection of the carriers receipt date in this methodology. At a minimum, carriers may not pay the claim until the payment floor is met, usually 14 days after receipt of the claim. Therefore it makes sense to use the carrier receipt date plus 14 days to begin counting the number of days in interest Medicare lost.